

## CHAPTER 5

### THE PLANNED SYSTEM OF CARE FOR ADULTS

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#### WHAT ARE THE MISSION AND VALUES FOR THE SYSTEM OF CARE FOR ADULTS?

The mental health constituency envisions a society in which adults with mental disabilities and their families can develop the skills and acquire the supports and resources they need to succeed where they choose to live, learn, and work and to be responsible members of the community. This vision is best achieved through the development of a culturally competent, community-based system of care that treats adults with mental disabilities with dignity and respect, empowers them to take an active role in their recovery, and is sensitive to the unique cultural and linguistic needs of the consumers it serves. The purpose of creating a public mental health system that promotes wellness is to assist adults with mental disabilities to accomplish the following goals:

- ◆ To be healthy
- ◆ To live where they choose
- ◆ To engage in school, work, and other satisfying and productive daily activities
- ◆ To have adequate income
- ◆ To be safe and abide by the law
- ◆ To have supportive relationships with others and meaningful connections to their communities

The development of the community mental health system began with deinstitutionalization in the 1960s. The mental health system was faced with the fact that people with mental illness have residential, vocational, educational, and social needs and wants. In the 1970s, the community support system was developed to identify the essential components needed by a community to provide adequate services and support to persons with mental illnesses (National Institute of Mental Health, 1987). The community support system was defined as “a network of caring and responsible people committed to assisting a vulnerable population meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community” (Turner & Shifren, 1979, p.2). In the 1980s, the concept

of psychiatric rehabilitation began to emerge. The rehabilitation model emphasized that mental illness not only causes mental impairments but also causes the person significant functional limitations. The rehabilitation model emphasized treating both the illness and its social consequences.

#### Wellness and Recovery

Education and training in the Recovery... [Vision] will help consumers acquire new skills and develop an understanding of their ability to make choices. They will learn to be less judgmental toward themselves and others as they learn to manage not only the functional aspects of their lives but also the biological, psychological, social, and spiritual dimensions of their experience (Mahler, Tavano, Gerard, & Baber, 2001).

California’s mental health system is promoting wellness and recovery as a fundamental value for its Adult System of Care. A recovery-oriented system promotes a commitment to person-centered services that work toward an individual’s needs, goals, and quality of life. Recovery emphasizes a shift from a provider-based system of care to a system that values a network of support that is both provider-based and client-directed. Providers engage clients to create and manage their own individual treatment plans actively rather than treating clients as passive, dependent recipients of care. William Anthony, one of the foremost authors to write about recovery for persons with mental illness, provides the following description of recovery:

Recovery is described as a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Shifting to a recovery philosophy in mental health treatment means helping clients to identify and pursue meaningful activities and active roles in the community by giving them both the hope and the expectation that they can be an integral part of society. Mary Ellen Copeland, a recovering client and national leader in the recovery movement, emphasizes the importance of hope in recovery:

We don't need dire predictions about the course of our symptoms—something that no one else, regardless of their credentials, can ever know. We need assistance, encouragement, and support as we work to relieve the symptoms and get on with our lives. We need a caring environment without feeling the need to be taken care of (Mead & Copeland, 2000).

Resiliency or bouncing back from a relapse is one aspect of recovery. Tapping into a client's resilience can promote the healing process that is integral to recovery. According to Courtney Harding, Director of Boston University's Institute for the Study of Human Resilience, "Resilience is part of the human spirit. . . It's that natural urge people have toward health, and it's what people use when they dig deep to overcome a real crisis. It's a process of taking back control of your life and reinventing yourself" (Craig, 2001, p. 3).

Although the notion of recovery is being embraced by many clients, family members, and providers, some individuals may be concerned by this term. Some may feel pressured, and others may worry about meeting new expectations and losing access to services. Providers need to understand and respect that each individual is unique and achieves recovery differently. The concept and experience of recovery may also be different for clients with different cultural and ethnic backgrounds. The mental health system must explore how a recovery vision can reflect the experience and values of the diverse cultural and ethnic groups in the State. In its Adult System of Care Framework, the California Mental Health Directors Association observes that, "The cultural identities and worldviews of the consumers shape health and healing beliefs, practices, behaviors and expectations. Wellness is therefore, uniquely defined by each individual and each cultural group" (California

Mental Health Directors Association, 2000, p. 2).

**Problem:** The public mental health system does not consistently promote recovery.

Providing mental health services may unintentionally foster ongoing dependence on the mental health system rather than promote recovery. Concerns have been raised that in many counties staff are not adequately trained to provide recovery-oriented services, including developing treatment plans with a wellness/recovery orientation. Many clients may lack access to or are denied ongoing support services that will help them to make progress toward their recovery. Providing services in a recovery-oriented system requires mental health staff to rethink what types of services may support recovery. In a recovery-oriented treatment system, traditional forms of treatment, such as medications and psychotherapy, are used as tools to help promote recovery rather than just to control the client's symptoms.

Several efforts are underway to address this problem. The California Mental Health Directors Association, working with representatives of the mental health constituency, has developed an Adult System of Care framework that embraces recovery-oriented services (California Mental Health Directors Association, 2000). This framework is intended to provide guidance on mental health policy and program development activities at the state, regional, and local levels of service delivery.

In the spring of 2002, the State Department of Mental Health and the California Institute for Mental Health (CIMH) developed and conducted four trainings throughout the State to teach clinicians and providers recovery-oriented service planning. In addition, the Department and CIMH conducted two more training sessions to train trainers in order to disseminate this approach in the counties. However, these "trainer training sessions" were attended by representatives from only 20 counties. More training sessions need to be held throughout the State. Although budget constraints may continue to hamper efforts to recruit trainers, more outreach needs to occur in those counties that have not participated in this training.

Many counties contract with and promote client-operated or peer support services.

These services are a very effective means of educating and encouraging clients about recovery. Clients who have experienced the challenges of mental illness can relate to other clients first hand and share their experiences in recovery. Providing peer-support services is very effective; however, difficulties arise in supporting consumer-run services because these services are paid for through realignment funding and cannot be matched for reimbursement through Medi-Cal. Because of budget constraints, some counties continue to fund traditional services, such as day treatment, because they receive a 50 percent match with Medi-Cal funds rather than fund a peer-support program that requires 100 percent state realignment funding.

Providing recovery-oriented mental health services is especially important for first-time users of the mental health system. Instead of receiving messages of stigma and despair, these new clients can be offered a positive vision of the future for themselves and a sense that they can have a meaningful role in life despite having a mental illness. Educational tools are being developed to convey hopeful messages of recovery. CIMH intends to develop training to teach clients and family members how to provide training on recovery in order to continue dissemination in the counties. However, the availability of resources may limit this effort. Mary Ellen Copeland has developed a program for clients called the Wellness Recovery Action Plan (WRAP). This program educates clients on how to develop increased self-awareness, improve self-care, and strengthen their supports. Similarly, the National Alliance for the Mentally Ill in California, with support from the DMH, has developed a training program for family members called "Family-to-Family." This program educates family members on mental illness and helps them understand what clients experience and the services that are available to help them. Many counties use both WRAP and Family-to-Family training in their mental health programs.

The National Association of State Mental Health Program Directors conducted a review of recovery literature and has summed up the ongoing challenge of fully integrating the recovery approach into the mental health system:

Although recovery activities and literature are increasing at an enormous pace, it is still a young and tender concept that is not fully developed. Achieving a recovery-oriented public mental health system will take a tremendous amount of dialogue, study, listening to each other and implementing the actual precepts of recovery including working together; treating each other with respect and dignity; and allowing, helping and encouraging consumers/survivors to "stay in the driver's seat" and take control of their lives (Ralph, 2000).

**5.1. Recommendation:** County mental health staff, provider organizations, consumers, and family members should be trained in the values and principles of recovery and in the evidence supporting it. They should actively support recovery processes and the development of mental health services that enhance each consumer's recovery.

- a. The DMH should place a high priority on funding training for county mental health staff on how to provide recovery-oriented services.
- b. County mental health departments should make recovery and training programs, such as WRAP and "Family-to-Family," more widely available to clients, family members, and providers.

**5.2. Recommendation:** The DMH should convene a work group to evaluate the effectiveness of consumer-operated services, study the sources of funding for these services, examine the adequacy of resources for consumer-operated services, and research ways to increase funding for these services.

## WHAT ARE THE PRIORITY TARGET POPULATIONS IN THE SYSTEM OF CARE FOR ADULTS?

### Statutory Definition

The impetus to develop California's adult target population definition began as a result of limited resources in the 1970s and 80s. County mental health departments had only a fixed amount of resources to provide to persons with mental illnesses. In most cases, this fixed amount was not sufficient to provide services to everyone that needed them. Counties were

forced to prioritize service delivery so that only those clients whose symptoms were most severe were treated.

With the passage of the realignment legislation in 1991, the adult target population definition was put in statute. Welfare and Institutions Code Section 5600.3 describes the target population for adults with mental illness who are served by the public mental health system. That definition states that a client's mental illness must be severe in degree and persistent in duration; may cause behavioral functioning that interferes substantially with the primary activities of daily living; and may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time.

### **Medi-Cal Managed Care Medical Necessity Definition for Recipients of Specialty Mental Health Services**

With the consolidation of fee-for-service Medi-Cal mental health services and public Short-Doyle Medi-Cal mental health services, a "medical necessity definition" was developed to apply to both groups of Medi-Cal beneficiaries who now receive mental health services through the public mental health system.

#### ***Medical Necessity for Inpatient Mental Health Services***

Section 1820.205 of the regulations governing the Medi-Cal inpatient mental health services defines medical necessity for inpatient services. A beneficiary must have a specified diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV) and require psychiatric inpatient hospital services as the result of a mental disorder due to certain symptoms or behaviors.

#### ***Medical Necessity for Outpatient Mental Health Services***

Section 1830.205 defines medical necessity for outpatient, or "specialty," mental health services. Beneficiaries must have a DSM-IV diagnosis with a significant impairment related to the diagnosis or the probability of significant deterioration or lack of developmental progress. Eligible care for medically necessary services must be focused on the impairment, the client must be expected to benefit from

the intervention, and the conditions should not be responsive to treatment that could be provided by the physical health care system.

Problems can arise for ethnically diverse populations when clinicians develop a diagnosis for the medical necessity definition. *Mental Health: Culture, Race, and Ethnicity--A Supplement to Mental Health: A Report of the Surgeon General* reports that minorities tend to receive less accurate diagnoses than whites. One reason for that phenomenon is the impact of culture, race, and ethnicity on the symptoms and expression of mental disorders. The DSM-IV acknowledges the role of culture on symptom expression with the inclusion of the "Outline for Cultural Formulation" and a "Glossary of Culture-Bound Syndromes." These sections describe the broader cultural context in which a multicultural client's symptoms must be evaluated and the ways they may differ from those of clients from Western cultures.

Clinicians must recognize and assess the different symptom presentations of multicultural populations and be careful when applying the definition of medical necessity across cultures. For example, some cultures express emotional distress through physical symptoms. Mexican American cultures may report stomach disturbances, chest pains, or palpitations (Escobar, Burnam, Karno, Forsythe, & Golding, 1987). Asian cultures tend to report cardiopulmonary symptoms, dizziness, vertigo or blurred vision (Hsu & Folstein, 1997). Multicultural clients must be assessed very carefully because they could be referred incorrectly to physical health care services or denied access to mental health care services as a result of an incorrect diagnosis.

**5.3. Recommendation:** The DMH and county mental health programs should develop strategies to ensure that the application of the medical necessity definition does not disproportionately restrict access to mental health services for multicultural groups.

- a. Clinicians should be trained in the use of the "Outline for Cultural Formulation" in the *Diagnostic and Statistical Manual IV* when developing diagnoses for clients from ethnically diverse populations.

## WHAT PROBLEMS EXIST IN THE ADULT SYSTEM OF CARE?

This section of the report addresses a variety of problems that exist in the Adult System of Care. These problems may limit access to mental health services and related services, such as education, employment, and housing; may affect the quality of mental health services; or may reduce the quality of life for adults with serious mental illnesses. Each problem is described and recommendations are offered to address the problem.

### Access

**Problem:** Clients often do not have timely access to mental health services.

Access to mental health services is obviously a prerequisite for achieving positive outcomes for clients. Chapter 3 indicates that an overwhelming number of adults in need of public mental health services do not have access to them. At best, lack of access means that clients do not improve and may become more ill. At the other end of the spectrum, however, one of the worst possible outcomes from lack of access is the increased risk of clients committing suicide. The Suicide Prevention Advocacy Network (SPAN) of California states that, of the 30,000 suicides that occur each year, most of them result from depression or other forms of mental illness. In fact, SPAN reports that 90 percent of persons who commit suicide have a mental disorder or substance abuse disorder. However, the mental health system is limited by its lack of resources and services in the community.

Lack of resources to fund mental health services can be attributed to several factors. First, as discussed in the previous section, the public mental health system has two primary sources of funds for mental health services: Medi-Cal and realignment funding. Many clients are not eligible for Medi-Cal benefits. For these clients, counties must still prioritize services based on whether these clients meet the target population definition established in the realignment statute. Counties must pay for services provided to these clients through limited public mental health dollars that are allocated from realignment funding.

The second factor contributing to lack of resources is that any augmentations that have been appropriated by the Legislature over the

last few years have been specific categorical augmentations that have improved access for some clients, such as clients who are homeless or who have been incarcerated. Although these programs are also needed, the mental health system really needs a substantial general augmentation to its funding so that timely access to services is available for all clients who seek mental health services. Local mental health programs also need additional unrestricted funding so that they can allocate funds to meet local priorities rather than develop programs only for specialized populations.

**5.4. Recommendation:** The State should appropriate additional non-categorical funds for mental health services for adults.

**Problem:** Persons of diverse cultural, racial, linguistic, and ethnic backgrounds lack access to health care services, which in turn restricts access to mental health services.

The Surgeon General's Supplement on Race, Culture, and Ethnicity points out that

Many racial and ethnic consumers and families prefer to receive mental health services through their primary care physicians. Explanations of this preference may be that members of minority groups fear, feel ill at ease with, or are unfamiliar with the mental health system. Community health centers as well as other public and private primary health settings provide a vital frontline for the detection and treatment of mental illnesses and co-occurrence of mental illnesses with physical illnesses...Developing strong links between primary care providers and community mental health centers will also assure continuity of care when more complex or intensive mental health services are warranted (U.S. Department of Health and Human Services, 2001, p. 163).

However, the Surgeon General's report also indicates that health insurance coverage is a major problem for ethnic populations and describes shortfalls in insurance coverage for the four major ethnic groups. The report states that nationally 37 percent of Latinos are uninsured, which is more than double the percentage for whites. Medicaid and other public coverage reach 18 percent of Latinos

(Brown, Wyn, Hongjian, Valenzuela, & Dong, 1999). About 21 percent of Asian Americans and Pacific Islanders lack health insurance, and the rate of Medicaid coverage for most Asian American and Pacific Islander subgroups is well below that of whites. Only about half of American Indians and Alaska Natives have employer-based insurance coverage, which contrasts with 72 percent of whites with coverage. Medicaid is the primary source of coverage for 25 percent of American Indians and Alaska Natives. 24 percent of American Indians and Alaska Natives do not have health insurance. Nearly one-fourth of African Americans are uninsured, a percentage 1.5 times greater than the white rate (Brown, Ojeda, Wyn, & Levan, 2000). Medicaid...covers nearly 21 percent of African Americans (Snowden & Thomas, 2000).

**5.5. Recommendation:** Local mental health providers should develop specific strategies to encourage the delivery of integrated primary health and mental health services that match the needs of the diverse communities they serve.

**5.6. Recommendation:** Health care providers should be trained to identify and refer more complex cases to mental health providers and to improve liaison relationships between primary care providers and mental health providers.

**5.7. Recommendation:** Local mental health providers and physical health plans should educate ethnic communities on identifying mental health problems and accessing specialty mental health services.

**Problem:** Disparities exist in access, quality, and availability of mental health services for racial, cultural, and ethnically diverse populations.

The Surgeon General's Supplement on Mental Health: Race, Culture, and Ethnicity documents the existence of striking disparities for minorities in mental health services. Racial and ethnic minorities have less access to mental health services than do whites. A major finding of the Surgeon General's Supplement is that racial and ethnic minorities bear a greater burden from unmet mental health needs and, thus, suffer a greater loss to their overall health and productivity. The report states that

...minorities are over-represented among the Nation's vulnerable, high-need groups, such as homeless and incarcerated persons. These subpopulations have higher rates of mental disorders than do people living in the community. Taken together the evidence suggests that the disability burden from unmet mental health needs is disproportionately higher for racial and ethnic minorities relative to whites. The greater disability burden to minorities is of grave concern to public health (p. 3).

The Surgeon General's report describes a number of barriers that contribute to these disparities in access, indicating that

The foremost barriers include the cost of care, societal stigma, and fragmented organization of services. Additional barriers include clinicians' lack of awareness of cultural issues, bias, or inability to speak the client's language, and the clients fear and mistrust of treatment. More broadly, disparities also stem from minorities' historical and present day struggles with racism and discrimination, which affect their mental health and contribute to their lower economic, social, and political status (pp. 3-4).

As the U.S. population becomes more diverse, medical and mental health providers and other people involved in mental health care delivery are interacting with clients from many different cultural and linguistic backgrounds. Because culture and language are vital factors in how mental health care services are delivered and received, mental health providers must understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse clients bring to treatment. Providing culturally and linguistically competent services to diverse clients has the potential to improve access to care and quality of care and, thus, should produce positive mental health outcomes.

**5.8. Recommendation:** The DMH and county mental health programs should track utilization rates to determine if significant disparities in access and retention for multicultural communities exist in California. If so, plans

should be developed to correct these disparities.

**5.9. Recommendation:** The DMH and county mental health programs should design services to address differences in culture, race, ethnicity, gender, and age to reduce barriers to access and treatment.

**5.10. Recommendation:** Local mental health providers should implement strategies identified in their counties' Cultural Competency Plans to address disparities in access for ethnic populations.

- a. Local mental health providers should conduct annual outreach campaigns to improve access consistent with the county's Cultural Competency Plans that are targeted to the underserved ethnic populations identified in their counties.
- b. Local mental health providers should develop programs in settings where the overrepresentation of vulnerable, high-need, racial, ethnic, and cultural populations are found, such as jails, homeless shelters, and refugee resettlement programs.

## Health

### *Physical Health Care*

**Problem:** Clients' physical health problems often go undetected, untreated, or inappropriately diagnosed.

Many studies have shown a very high prevalence of serious physical illnesses in persons being treated for mental illness. These physical illnesses are often undetected or untreated because the client cannot effectively communicate the physical symptoms and physicians often attribute somatic symptoms to the mental illness. Kaplan, Sadock, and Grebb (1998) states that between 24 to 60 percent of persons who have been identified in the target population have been shown to suffer from associated physical disorders. In 1985, in response to Chapter 208, Statutes of 1982 (SB 929), Koran studied the prevalence of undiagnosed and untreated physical diseases in clients under the care of county mental health systems in four California counties (Koran, 1985). The study revealed that 45 percent of the clients had acute physical diseases. Twenty-two percent had their disease detected

at the time of intake into the mental health system, and 23 percent of the clients had diseases that remained undiagnosed.

Kaplan et al. (1998) states:

Among the most inappropriately treated patients in the mental health system are those who have medical problems that either cause or contribute to their psychiatric symptoms. Study after study has shown that psychiatric patients have more medical problems than the average members of society and that the most severely psychotic in this population have the most serious and/or the greatest numbers of medical problems (Kaplan, Sadock, & Grebb, 1998, page 152).

With the advent of managed mental health care in the public sector, California's mental health system "carved out" its services into specialty mental health services designed to serve Medi-Cal beneficiaries whose mental illnesses meet the medical necessity definition criteria. (See Chapter 7, Managed Mental Health Care, for more information on this system.) County managed health care plans, which are responsible for providing physical health care to Medi-Cal recipients, and county managed mental health plans have developed memoranda of understanding to coordinate care. This coordination includes providing clinical consultation and training, referral protocols, exchange of medical records information, and a process for resolving disputes between plans.

Egnew and Geary, describing the interface with health care in a carved-out mental health care system, report that the challenges of coordinating care include ensuring a timely process for referral, information sharing, consultation, and ensuring easy and timely access. They believe that "ensuring adequate access to both medical/surgical and behavioral healthcare is a critical public policy issue" (Egnew & Geary, 1996, p. 67).

Primary care providers actually see a large percentage of clients with significant psychiatric diagnoses. The California Medical Association estimates that about 80 percent of persons with mental illness are seen first by primary care physicians (California Medical Association, 1998). Primary care physicians

should be able to identify these illnesses accurately and make the appropriate diagnosis or refer clients to specialty mental health services. If mental illnesses are identified and treated in a timely manner, client outcomes are better and treatment is more cost-effective. In 1998, the California Medical Association adopted a resolution to collaborate with other organizations to provide mental health training for primary care physicians (California Medical Association, 1998). Although the problem has been addressed, it has not been solved.

Gender issues in access to health care services also need to be addressed. Although women utilize health care services more than men do, they still face significant barriers, including lack of or inadequate health insurance coverage. Services to meet the needs of women who face trauma, severe depression, eating disorders, or other psychological disabilities are insufficient (California Institute for Mental Health, 1999).

**5.11. Recommendation:** Mental health clinicians should ensure that clients entering the mental health system receive thorough physical exams.

**5.12. Recommendation:** Mental health providers should encourage clients to use health care, especially education and prevention services, such as smoking cessation programs.

#### ***Co-occurring Mental Illness and Drug and Alcohol Use***

The DMH estimates that approximately 60 percent of persons with serious mental illnesses have a substance abuse problem and that up to 90 percent of the highest cost users of mental health services also abuse substances (California Department of Mental Health, 1997a, page 16). The DMH describes the effect that co-occurring disorders are having on the mental health system:

Within the last decade, it has become increasingly clear that substance abuse and mental illness when occurring simultaneously present a synergistic force that exacerbates both problems. Persons with a co-existing disorder are among the highest cost users within the publicly funded health care and criminal justice systems, and are a

public safety concern when left untreated (California Department of Mental Health, 1997b, p. 1).

The Program for Assertive Community Treatment (PACT) Model describes the challenges faced by clients with co-occurring mental illness and alcohol and drug use:

Clients with dual diagnosis present a substantial treatment challenge to mental health systems. As compared with other clients, their functioning is poorer (e.g., increased symptoms and impairment, hospitalization, incarceration, homelessness, physical problems), and they are more difficult to treat and rehabilitate (e.g., less adherent with mental health and substance abuse treatment services, showing a greater complexity of problems and needs) (Allness & Knoedler, 1998, page 58).

**Problem:** The mental health system lacks integrated treatment programs for co-occurring mental health and alcohol and drug use.

Historically, treatment of mental illness and substance abuse has been addressed by separate programs typically under separate government departments or agencies. Basic treatment philosophies between the two systems differ substantially. Many substance abuse treatment programs require total abstinence from any substance, which poses a problem for mental health clients with substance abuse problems who must take medications to control their mental illnesses. The DMH states that, "It is imperative that attempts to address issues of dual diagnosis take place as an integrated and unified program. Integrated service delivery for both problems has been shown to be highly cost-effective" (California Department of Mental Health, 1997b, p. 1).

In May 1995, the DMH and State Department of Alcohol and Drug Programs (ADP) formed the Dual Diagnosis Task Force. The purpose of the task force is to support the development of and promote effective programs for clients with dual diagnosis, to foster cooperative efforts in the treatment of this group of clients at the local level, and to promote access to those treatment programs. The DMH and ADP awarded \$3 million over a three-year period in federal Substance Abuse and Mental Health



Services Administration (SAMHSA) funds to four projects. Each project is designed to demonstrate the efficacy of integrated mental health and alcohol and other drug treatment/recovery programs for persons with a dual diagnosis in a county system of care. The projects concluded in 2001, and the task force has completed its evaluation, which is currently in review. The evaluation will provide data on the effectiveness of integrated treatment, clinical outcomes, consumer satisfaction, client quality of life, costs, and cost savings or avoidance in the area of physical health care and criminal justice.

In 2001, the DMH also awarded two three-year demonstration grants to Sacramento and San Joaquin counties for dual diagnosis demonstration projects that target culturally diverse underserved populations. A major goal of these projects is to improve the coordination of mental health and substance abuse services between programs or across counties in order to maximize the utilization of supports and services and to minimize administrative, fiscal, and program barriers to services. However, due to budget constraints, the grant amounts were reduced and the third year of the projects was eliminated.

At the federal level, SAMHSA is beginning to expand its philosophy regarding treatment for clients with co-occurring disorders. A recently released report to Congress on co-occurring disorders outlines a five-year plan to ensure accountability, capacity, and effectiveness in services for persons with a dual diagnosis. One of the main points in the report is how to use available funding streams to serve people with dual diagnoses, which has been a point of contention between mental health and substance abuse providers for years. The policy under consideration would allow states to use federal block grant funds from both the mental health and substance abuse block grants to support integrated services although funding from both block grants would still have to be used in accordance with the purposes for which they are authorized by law. SAMHSA's intent is to ensure that clients receive the services they need and that states receive the most flexibility possible (Manisses Communications Group, 2002).

**5.13. Recommendation:** If the dual diagnosis pilot projects prove to be effective, the DMH and the ADP should seek funding to expand

integrated treatment programs for clients with co-occurring diagnoses by offering incentives or matching funds to counties that replicate these models.

**5.14. Recommendation:** The DMH and the ADP should collaborate to explore all available options for using their federal SAMHSA block grants to fund integrated treatment programs for clients with co-occurring diagnoses, including taking advantage of new SAMHSA policy initiatives.

### Living Situation

**Problem:** The mental health system lacks housing at all levels of the residential continuum.

The DMH reports that approximately

...seven percent of the adult population in the United States, or about 12 million Americans, have been homeless at least once in their lives. More than three-quarters of homeless single adults have persistent mental or physical illnesses or substance abuse problems. In California, at least 150,000 people are homeless, and studies indicate that at least half are disabled with mental illness, medical problems, or other health conditions (California Department of Mental Health, 1998, p. 1).

A report prepared by the State Independent Living Council in April 1999 states that,

Housing affordability is a major problem in California...There is a severe scarcity of low-income housing in communities throughout California, notably in major metropolitan areas. Individuals who rely exclusively on Supplemental Security Income (SSI) cannot pay the prevailing or market rental rate for any type of decent apartment or house...Given the lack of low-income, accessible housing, increasing numbers of people with disabilities are forced to choose between restrictive congregate settings and homelessness" (Tootelian & Gaedeke, 1999, p. vii).

In California, the Supplemental Security Income/State Supplemental Program (SSI/SSP) is only \$692.00 per month for most clients,

which is an insufficient income in many counties. In fact, at the June 2000 meeting of the California Mental Health Planning Council, a client testified that in San Mateo County clients are living with four or more clients in a small two-bedroom apartment and giving up half or more of their SSI/SSP check for rent. The rest of the money goes to buy the food and other necessities they will need for the month.

Persons with mental illnesses face multiple barriers to finding and maintaining safe, affordable housing. Besides lacking adequate income, many people have co-occurring disorders, including alcohol and other drug abuse problems and acute or chronic physical health problems. They also face stigma associated with their illnesses and the fears of potential landlords or neighbors. Women who are homeless and mentally ill face additional gender/role barriers. They are more vulnerable to sexual trauma and violence. Some women are reluctant to access housing services for fear that their children may be taken away from them. Often, housing programs have rigid guidelines for women using the facilities. Women may not be able to comply with the rules if they have children in their care or other problems.

Persons with mental illnesses need the support of community mental health services to be able to maintain housing in the community. They also need access to a full continuum of housing, from crisis residential facilities through permanent supportive housing. The community residential treatment system, which was established in the 1980s, provides for a complete array of housing to meet the level of need of each client. The common thread among these programs is individualized focus on consumer needs and a rehabilitation and recovery-oriented philosophy. Some advocates, however, believe that although persons with mental illnesses have varying needs for support at different times in their illnesses, their housing does not necessarily have to change as those needs change. They believe that forcing an individual to move just when he or she has achieved some level of comfort and competence in a particular living situation may be detrimental and that housing arrangements should be permanent with flexible supports provided onsite or offsite for as long as the individual needs or desires them.

Regardless of what stakeholders believe is the best housing philosophy for mental health clients, the overall problem is lack of housing at all levels, which contributes to homelessness and inappropriate institutionalization. In some counties, housing is nonexistent, and clients must be sent to facilities in other counties to live. Many acute care hospitals must keep clients in an acute care setting for lack of placement in the community. This issue is becoming increasingly more critical. To make matters worse, California is experiencing a decline in board and care residences. Although board and care residences are viewed by many advocates as less than ideal housing for mental health clients, in many cases, these residences have been the only affordable and available housing option. The board and care rate under SSI is so inadequate that many board and care operators are evicting persons with mental illnesses who only receive SSI in order to provide services to persons who receive a county rate augmentation or "patch." Others are asking family members to pay the difference between SSI rates and market rates. Many providers are going out of business altogether, and many of the board and care residences that continue operate substandard programs that do not even meet minimum licensing requirements.

Although many clients want to live independently, some clients may have different goals due to cultural and ethnic differences. The mental health system needs to take into account how such differences might influence a client's preferred living arrangement. Housing should be culturally congruent. Independent housing may not be the ultimate goal of clients from different cultural backgrounds. For example, in some Asian families, young adults are expected to live with their families until they get married. In some Latino families, reintegration with the family may be the goal.

**5.15. Recommendation:** The State should provide more resources to mental health programs to provide for a full continuum of housing to mental health clients.

**5.16. Recommendation:** The DMH should encourage housing programs to reduce restrictions that present barriers to women with mental illness, including women with children. Programs should engage in outreach to women with mental illness, offer community support tailored to their needs as caregivers,

and be flexible in their requirements so that they do not preclude serving women with children.

### ***Federal and State Efforts To Provide Housing***

The DMH has received federal homeless funds through the Stewart B. McKinney Homeless Block Grant since 1985. Beginning in 1991, the funding came through the McKinney Projects for Assistance in Transition from Homelessness (PATH) formula grant. Each county with PATH programs has established one or more programs of outreach or services to persons who are homeless and have a mental illness.

In fiscal year 1998-1999, the DMH assumed an active role in the development of supportive housing for persons with serious mental illnesses who are homeless or at risk of homelessness. The DMH redirected increases from the PATH and SAMHSA programs to initiate a competitive grant process that resulted in mental health funding of 13 supportive housing demonstration projects in both rural and urban counties.

Additionally, pursuant to the California Supportive Housing Initiative Act, (Chapter 310, Statutes of 1998), the DMH became the lead agency in administering supportive housing grants for low-income persons with serious mental illnesses and/or other special needs populations. This legislation also established the Supportive Housing Program Council, which is comprised of representatives from state agencies, consumers, and family members who provide recommendations and support to the DMH in administering this grant program. Under the Supportive Housing Initiative Act, six supportive housing projects were funded in fiscal year 1999-2000, and five have been funded this year. The Budget Act for fiscal year 2000-2001 has provided an additional \$25 million for additional new projects.

**5.17. Recommendation:** The DMH should continue its efforts in the statewide expansion and development of new supportive housing grants through both state and federal funding.

### ***Olmstead v. L.C.***

**Problem:** The number of residents in institutions for mental disease is increasing.

The United States Supreme Court ruling in the case of **Olmstead v. L.C.** issued in June 1999

stated that the Americans With Disabilities Act (ADA) requires that services be provided in the most integrated setting appropriate. The Olmstead decision requires that individuals who could benefit from community placement be identified and assessed for need of community services. These services must be made available in a reasonable period of time so that these individuals can transition to the community. California is obligated under the Olmstead decision to develop an effective working plan for transitioning individuals who can benefit from community services out of institutions and into the community. The Olmstead Plan is being developed by the Long-Term Care Council established by the California Health and Human Services Agency. The Long Term Care Council conducted local forums during September 2002 so members of the public and stakeholder organizations could provide input on community needs, preferences, and options for community living. It will convene the Olmstead Plan Work Group to address Olmstead implementation and intends to review recommendations that the Work Group generates from the local forums in January 2003.

In addition to the activities of the Long Term Care Council, the federal Center for Mental Health Services (CMHS) is assisting states to expand resources and opportunities for people with mental illness to live in their communities. The CMHS has offered annual grants for a total of three years to state mental health agencies for the purpose of organizing and supporting the activities of state-level coalitions to promote community-based care. To implement this grant, the DMH has contracted with the California Institute for Mental Health (CIMH) for a project coordinator to assist the Olmstead Plan Work Group in analyzing and reporting on the information and recommendations that are made at the local forums.

Many individuals in California who could benefit from community services remain institutionalized. As the number of civilly committed residents in state hospitals declines, the number of residents in institutions for mental diseases (IMD) is increasing. IMDs, which are primarily locked nursing facilities, have become a substitute form of institutionalization.

The State and the counties have an obligation under the Olmstead decision to reduce the use of IMDs. In addition, counties have a strong financial incentive to do this as well because mental health costs for most residents in IMDs are not reimbursable by Medi-Cal, and counties must fund these placements with 100 percent county dollars. Clearly, IMDs are not cost-effective. However, because local mental health programs lack a full array of residential treatment and affordable housing for mental health clients in California, they have difficulty placing many clients in less restrictive care.

One option for helping clients transition from IMDs into community placements is the IMD Transition Grant Program. This initiative was developed by the Long Term Care Council and is being implemented by the DMH, which will award grants to two programs. This program will address the expansion of community-based options for individuals currently residing in IMDs, including culturally competent, recovery-based services, protocols that can be replicated for determining placement readiness, community services needed, and the identification of barriers to placement. Unfortunately, the program, which was originally funded for three years, is being reduced to two years due to budget constraints. In fact, because the funding comes from the state General Fund, this program may be cut altogether from the budget for fiscal year 2002-03.

**5.18. Recommendation:** The DMH and county mental health departments should implement the Olmstead plan developed by the Long Term Care Council

**5.19. Recommendation:** The DMH should prepare a report with current data on IMDs, including their locations, populations, costs, average length of stay, residents' county of origin, and other relevant data. The report should make recommendations regarding options to reduce reliance on these facilities and to promote community integration and more cost-effective care.

**5.20. Recommendation:** If the IMD Transition Grant Program grants prove effective, they should be expanded to additional counties in California.

## Productive Daily Activity

Productive daily activity includes engaging in meaningful daily activities, including education and training, volunteer activity, and competitive employment.

### *Education Supports and Reasonable Educational Accommodations*

**Problem:** California lacks sufficient education supports and reasonable educational accommodations for persons with mental disabilities.

New opportunities to obtain a college education have opened up for mental health clients as Jackie Groshart, Psychological Disabilities Specialist, explains:

Individuals with major mental illness often experience their first symptoms at the age when they would typically be entering college. In the past, depending on the severity of the symptoms, they have either been unable to pursue their education or have been severely limited in this area. Today with the advent of extremely effective medication and adjunct therapy to control symptoms and with the passage of legislation that ensures the right to accommodations, an increasing number of these students are able to attend school successfully (Groshart, 1997).

Educational accommodations and auxiliary aids that help to level the playing field for persons with disabilities in higher education must also be provided to qualified students with psychiatric disabilities. In addition to mandated accommodations, postsecondary education institutions provide varying degrees of educational support services depending on the segment, the individual campus, and whether funding is private or public.

Reasonable accommodations and support services encourage individuals with mental disabilities to enter or re-enter adult, postsecondary, and technical education institutions. Examples of reasonable accommodations include assistance with registration, testing accommodations (extended time or taking tests alone with a proctor) to alleviate difficulty during timed tests, tape recorders in class to remedy easy distractibility, note takers to compensate for

poor concentration, access to special parking, and seating arrangement modifications. Examples of supports include access to campus counselors trained in psychiatric disabilities, peer supports, advocacy skills training, access to special classes, such as stress management and memory enhancement, assistance accessing campus services and resources, such as financial aid, and assistance with retention-related problems while hospitalized.

Access to reasonable accommodations and related services for students with mental disabilities can help them be successful in higher education. Campus counselors must have a combination of counseling skills, a supportive and nonjudgmental attitude, and the knowledge of disability issues, but they do not necessarily need to be specialists in psychiatric disabilities (Parten & Tracy, in press). Some postsecondary institutions provide specialized counselors for students with mental disabilities, and a few community colleges offer specialized programs. However, most college counselors for students with disabilities and most adult education counselors may be unaware of the needs of this population. Adult and higher education institutions that have access to a wide range of counselors, services, and relevant curricula are able to successfully accommodate, serve, and support a wider range of students with mental disabilities (Parten & Tracy, in press).

**5.21. Recommendation:** County mental health departments should initiate education supports in collaboration with adult, technical, and postsecondary education institutions and expand existing on-campus and off-campus supported education programs.

**5.22. Recommendation:** County mental health departments should train staff in providing education accommodations and how to document a disability-related educational limitation.

**5.23. Recommendation:** Clients' interest in pursuing adult or postsecondary education or technical training should be assessed. Clients should be informed of their legal right to accommodations in higher education settings and of the specific accommodations, services, supports, and resources available.

**5.24. Recommendation:** County mental health departments should advocate for more funding, training, and education of adult and

postsecondary education counselors who are specifically assigned to students with mental disabilities.

### **Employment**

The Surgeon General Report on Mental Health states that people with severe mental illnesses tend to be poor (U.S. Department of Health and Human Services, 1999). Although the reasons are not understood, poverty is a risk factor for some mental disorders as well as a predictor of poor long-term outcome among people already diagnosed. People with serious mental illnesses often become dependent on public assistance shortly after their initial hospitalization. The unemployment rate among adults with serious mental disabilities is approximately 90 percent. Women with mental disabilities have a lower employment rate than men with mental disabilities and appear to be underserved by rehabilitation services. Only 40 percent of people with mental illness who receive rehabilitation services are women (California Institute for Mental Health, 1999).

**Problem:** The mental health system lacks sufficient supported employment services for persons with mental illness.

The Surgeon General's Report also observes that an adequate standard of living and employment are associated with better clinical outcomes and quality of life. Although newer vocational rehabilitation and employment initiatives strive to remedy persistently high levels of unemployment, most consumers find themselves unable to work consistently or at all. This problem results from active symptoms, profound interruptions of education and employment caused by symptom onset and exacerbation, stigma and discrimination, lack of higher education programs, and being limited to low-paying, menial jobs.

The National Association of State Mental Health Program Directors (NASMHPD) describes the barriers to employment and the consequences of unemployment:

The lack of jobs that provide flexibility for adults with serious mental illness is a major barrier to successful community living, a personal loss to people who wish to work, a societal loss to employers and taxpayers, and a barrier to successful recovery for those with mental illness.

Chronic unemployment can lead to isolation, poverty, and a diminishing self-worth in any adult, hindering efforts at recovery. In addition, one residual effect of chronic unemployment for persons with psychiatric disabilities is the perpetuation of homelessness. The current high rate of unemployment among people with psychiatric disabilities—estimated at 85 percent—must be lowered. The focus should not only be on employment opportunities, but also on habilitation and rehabilitation, including integrated supported competitive employment to better enable individuals with mental illness to participate in the workforce (National Association of State Mental Health Program Directors, 2000).

Employment that is competitive, integrated, paid, and meaningful is of fundamental importance to the quality of life for persons with mental disabilities. The NASMHPD position statement on employment and rehabilitation makes the following points:

- ♦ State mental health authorities should assume a leadership role in significantly increasing the rate of employment among individuals with psychiatric disabilities.
- ♦ Vocational rehabilitation agencies and state mental health authorities should collaborate and design program linkages and develop a range of employment options to increase rehabilitation opportunities to individuals requiring mental health services.
- ♦ Mental health policymakers should work to maximize the availability of community supports and case management efforts that focus on employment issues early in the rehabilitation process.
- ♦ Employment support and rehabilitation standards must be flexible to accommodate the episodic nature of mental illnesses.
- ♦ Effective rehabilitation services must view successful rehabilitation for individuals with mental illness

differently than for others, adapting to the needs of all individuals with psychiatric disabilities.

- ♦ Employment support must be an integral component of comprehensive community support programs (National Association of State Mental Health Program Directors, 2000).

**5.25. Recommendation:** County mental health departments should initiate new supported employment programs and expand existing programs for persons with mental disabilities.

#### ***Department of Mental Health/Department of Rehabilitation Cooperative Programs***

County mental health departments and the California Department of Rehabilitation (DR) have joined together to provide an array of cooperative services throughout the State. These programs have been built with consumer and family member participation. They embrace the values of comprehensive service linkages; consumer career choice, placement in a competitive, integrated environment, reasonable accommodations, and ongoing support. Currently, 27 cooperative agreements exist. In addition, the DMH and the DR have an interagency agreement to provide coordinated vocational services for clients as they make the transition from state hospitals to local communities. Mental health professionals involved in these cooperatives continue to work with rehabilitation counselors through continuing education to identify the unique needs of persons with psychiatric disabilities.

**5.26. Recommendation:** The DMH/DR Cooperative model should be established in every county in California.

**5.27. Recommendation:** The DMH and DR should continue to provide staff with cross training about the needs of persons with mental disabilities.

#### **Financial Status**

**Problem:** Public assistance is not enough for clients to be able to afford anything other than the bare essentials.

Persons with mental illness should have an adequate income. According to the Department of Health and Human Services,

...people with serious mental illnesses often become dependent on public

assistance shortly after their initial hospitalization. The unemployment rate among adults with serious mental disorders hovers at 90 percent. Consequently, they must rely on government disability income programs, rent subsidies, and informal sources of economic support. Clients usually face such modest monthly budgets that there is no room for error. Funds are frequently depleted before the end of the month (U.S. Department of Health and Human Services, 1999, pp. 293-294).

**5.28. Recommendation:** The CMHPC should facilitate a coordinated advocacy campaign at both the federal and state level to increase income supports for persons with mental illness.

**Problem:** People have a disincentive or are afraid to work because they could lose their SSI/SSP or other benefits, such as Medi-Cal.

Being able to work does not preclude the need for long-term services and supports, such as counseling and medication. As the U.S. Department of Health and Human Services points out, those who work part-time, and even many with full-time jobs, may not be able to obtain adequate insurance through their employers to cover their ongoing medical needs. In addition, because of the long-term and fluctuating nature of some mental illnesses, people with psychiatric disabilities may continue to go through periods when they are unable to work, thus requiring the continuation of medical and other benefits (U.S. Department of Health and Human Services, 1999).

The National Council on Disability reports that a significant barrier to work is the possibility of losing benefits, "Many people with mental disabilities fear that if they work, the Social Security Administration (SSA) will declare them no longer disabled and therefore ineligible for further benefits, even though they have had no medical improvement. Because the probability of a recurrence is high, they are afraid to take the risk" (National Council on Disability, 1997, p. 2).

The National Alliance for the Mentally Ill (NAMI) has advocated at the federal level for flexibility in the Medicaid law to allow people

with mental illness to remain working while accessing health benefits:

People with severe mental illnesses and other disabilities should not be forced into (and stay in) poverty in order to access Medicare or Medicaid. At the same time, these programs need to remain in place as federal entitlements in order to ensure that persons whose symptoms or impairments are so severe that they cannot work are not at risk for losing cash benefits or health coverage (National Alliance for the Mentally Ill, 2000).

In 1999 the "Ticket to Work and Work Incentives Improvement Act" (PL 106-170) made improvements in disability programs, allowing Social Security Disability Income (SSDI) and Supplemental Security Income (SSI) beneficiaries to work to the greatest extent of their abilities. This Act shifted the philosophy behind the nation's public disability programs, including SSI, SSDI, Medicaid, and Medicare, to programs that foster work, independence, and self-sufficiency for persons with mental illnesses.

PL 106-170 allows States to offer Medicaid coverage to SSI beneficiaries who go to work and allows a Medicaid buy-in for persons with disabilities who earn more than 250 percent of the poverty level. California enacted Chapter 820, Statutes of 1999, which implemented this provision. Any employed person whose income does not exceed 250 percent of the federal poverty level and who is disabled for specified purposes is eligible for Medi-Cal benefits subject to a sliding scale.

**5.29. Recommendation:** Providers, clients, and families should be educated about the reporting requirements if a client returns to work while in receipt of SSI or SSDI and the provisions that may be available to extend a client's benefits upon return to work or to reinstate benefits should the client be unable to continue working.

### Legal Issues

**Problem:** Increased numbers of persons with mental illness are involved with the criminal justice system.

Factors contributing to the increase in persons with mental illness who are involved with the criminal justice system can be traced back to

the deinstitutionalization process of the 1960s as Izumi, Schiller, and Hayward (1996) explain:

The expectation was that those persons not treated in the state hospitals would instead be treated in community settings. Unfortunately, reality did not live up to the plans of advocates and policymakers, and the mentally ill who previously would have been sent to state hospitals were instead often asked to fend for themselves, either on the streets or in the nominal care of relatives. Placed in this situation, the poor judgment, lack of control, and deteriorating living conditions of the mentally ill resulted, not surprisingly, in increased arrest rates (Izumi, Schiller, & Hayward, 1996).

Now 30 years later, community mental health resources are still inadequate. The mental health system is so overburdened that only those persons with the most serious mental illnesses are served. Chapter 3, Unmet Need for Public Mental Health Services, indicates that the public mental health system only serves approximately half of the total population in need of services. In many cases, the system does not have enough resources to use for anything other than acute hospitalization, which is the most costly, high-end intervention.

In 1993, the Los Angeles Board of Supervisors established the Task Force on the Incarcerated Mentally Ill. The task force studied the increasingly high rate of incarceration of persons with severe mental illness and provided recommendations. The task force delineated the factors contributing to criminalization of persons with mental illness:

...it is clear that decreasing mental health resources and community support systems, increasing involvement of law enforcement officers with persons diagnosed with mental illness, insufficient intradepartmental and interagency collaboration, and very importantly, societal conditions disproportionately affecting persons with mental illness have resulted, at times, in the unnecessary criminalization of the target populations (Los Angeles County

Task Force on the Incarcerated Mentally Ill, 1993, page 18).

Chapter 617, Statutes of 1999 (AB 34) was enacted to provide outreach to adults with mental illness who are at risk of being homeless, who are homeless, or who frequently enter the criminal justice system. The goal of these programs is for communities to provide outreach, mental health care, and follow-up services for the homeless, including housing and employment assistance. Initially, funding was provided to three demonstration projects to determine the effectiveness of these programs. The success of these programs paved the way for increased funding, which was increased in the budget for fiscal year 2000-2001 to total approximately \$55 million. Chapter 518, Statutes of 2000 (AB 2034) added additional language that allowed for expansions of the existing programs and permitted additional counties to participate in these programs. Currently, 26 counties have been funded, including the three initial pilot programs.

**5.30. Recommendation:** The State should fully fund programs that prove to be successful in providing outreach, mental health care, and follow-up services, such as the programs established by Chapter 617, Statutes of 1999 (AB 34) and Chapter 518, Statutes of 2000 (AB 2034).

**Problem:** The criminal justice system lacks law enforcement training, diversion programs, and discharge planning to treatment programs.

Mentally ill offenders (MIOs) are persons with mental illness who commit a crime and enter the criminal justice system. These people may become involved with the criminal justice system because of a lack of services, homelessness, or substance abuse. Many are detained or arrested for a variety of petty crimes, such as shoplifting or creating a public nuisance. Some may be detained for crimes that are more serious. Often, law enforcement officers will detain these persons in order to divert them into the mental health system rather than arresting them for a misdemeanor, such as disturbing the peace, trespassing, and vandalism. However, with the limited availability of mental health resources, law enforcement officers are frequently unable to find alternatives to incarceration.



The Los Angeles Task Force on the Incarcerated Mentally Ill also found that, “there are some persons that require secure correctional detention and who should receive appropriate mental health services within the jail. It is imperative, however, to develop cost-effective and humane strategies for diversion of minor offenders to mental health settings and to provide them with the necessary community support systems, including housing, to prevent recidivism” (Los Angeles County Task Force on the Incarcerated Mentally Ill, 1993, page 18).

### ***Pre-Booking Interventions***

Pre-booking interventions usually occur at the scene of an incident. Pre-booking interventions require that police officers be trained in crisis intervention. Some counties have developed accredited training through Peace Officers Standards and Training (POST). In Monterey and Santa Clara counties, this 40-hour training course teaches law enforcement officers to make appropriate decisions without having to resort to force when confronting a person with mental illness who is in crisis or who is acting dangerously. In addition, non-uniformed mental health professionals may be employed by or under contract to local law enforcement agencies to assist patrol officers to respond to incidents. Mobile community mental health center employees may respond to such incidents as part of a team with police. Mental health staff based at community mental health centers cooperate with police in responding to such incidents.

### ***Post-Booking or Pre-Adjudication Diversion***

Post-booking or pre-adjudication interventions take place once a person has been arrested or incarcerated. These diversion programs usually require an offender to comply with a plan in order to be released. A public defender, court officials, and mental health officials may develop a release plan and present it to the judge at the initial court hearing. The judge may withhold final disposition of the case for a period of time to ensure the client’s compliance with the release plan.

**5.31. Recommendation:** Counties should advocate for all law enforcement officers to attend the POST-accredited 40-hour training course on mental health.

**5.32. Recommendation:** The DMH and other appropriate state entities should develop and

provide grants to counties to implement diversion programs.

**Problem:** Mentally ill offenders in jails lack appropriate care.

The jail environment is not conducive to helping a person with mental illness. The local jail frequently does not have adequate staffing to provide the screening needed to identify offenders with mental illness. The jails are overcrowded, often exacerbating the problems being experienced by the mentally ill offender. Jail staff frequently lack training in dealing with persons with mental illness. During the booking process, most jail settings do not provide enough crisis management. The number of mental health staff in the jails is insufficient to provide mental health services; staff can only triage the most serious cases and dispense psychotropic medications. Many inmates are released before their request for mental health care can even be met. In addition, release planning is insufficient. Mentally ill offenders are often released unsupported into the community only to reoffend. Jail is meant to punish or control and is not meant for the care of a person with serious mental illness.

Another major problem for mentally ill offenders is that the prescription drug formulary for jail medical services is outdated and does not include the newer psychotropic medications. A change in medication can cause further destabilization and impede any progress that has been made if an offender was being treated with the newer psychotropic medications.

**5.33. Recommendation:** Counties should develop effective policies and procedures for securing the safety of individuals who have been diagnosed with mental illness to improve the quality of mental health services in their jails. These policies should include the following:

- a) The local law enforcement agency should routinely screen all incoming detainees for mental illness.
- b) Additional positions should be provided in jails to enable jail mental health staff to respond to requests for mental health services, provide mental health interventions, and participate more fully in release planning.

- c) The jail medical formulary should include all of the latest psychotropic medications in order to ensure consistency with the client's current medication regimen and to ensure compliance.

**5.34. Recommendation:** Counties should adopt effective policies and procedures for screening and identifying all inmates for mental disorders, for providing appropriate mental health services, and for seamless transition into the community after release.

***Mentally Ill Offender Crime Reduction Program***

Chapter 501, Statutes of 1998 (SB 1485) established the Mentally Ill Offender Crime Reduction (MIOCR) program through the Board of Corrections with a \$50 million appropriation. This program provided three-year grants to county sheriffs in 15 counties to help support mentally ill offenders during incarceration. It also provides appropriate support for these offenders upon release. These programs are helping to build relationships between law enforcement and mental health by providing community mental health services to people who would otherwise be released from jail with no mental health support and who would be likely to be re-arrested shortly thereafter.

The Budget Act for fiscal year 2000-2001 provided an additional \$50 million to the Board of Corrections for this program, bringing the total amount of funding to \$100 million and expanding the total number of programs to 30 in 26 counties. The first set of counties are in their third year of funding, and the second set are in their second year of funding. However, the last year of funding for the second set of counties is in danger of being cut due to the State's fiscal crisis. Evaluations will be completed on all of the programs and will be available in June of 2004.

**5.35. Recommendation:** If the MIOCR programs are proven effective, the State should fund these projects in any remaining counties that do not have a program.

**Problem:** The local court systems are not prepared to deal with persons with mental illnesses.

Most local court systems have limitations in their dealings with mentally ill offenders. Judges are often at a loss as to appropriate

sanctions and punishment, and community treatment options are few or unavailable. A lack of coordination is evident when an inmate is released. For example, family members and community-based service providers are not informed of the date and time of a court hearing for a client they had supported or housed prior to incarceration. Many times, the judge will order an inmate's immediate release, which can take place in the early morning hours, without notifying anyone about the release.

**5.36. Recommendation:** Court officials should receive training to help identify, understand, and deal with persons with mental illness and with persons who have a co-occurring mental illness and substance abuse disorder.

**5.37. Recommendation:** All counties should establish an Interagency Policy Council, which includes the Mental Health Department, Alcohol and Drug Department, Sheriff's Department, Police Department, Probation Department, Superior Court, District Attorney, Public Defender, Housing Authority, Department of Social Services, Department of Health Services, Parole Department, Rehabilitation Department, clients, and family members. The duties of this council would be to coordinate discharge planning, provide consistent treatment of clients in jails, and implement and expand diversion programs.

**Problem:** Persons with mental illness are stereotyped by the public as being violent.

A study on violence and mental disability found that almost two-thirds of the public believes persons with schizophrenia are prone to violence against others (Monahan, Link, Stueve, & Kikuzawa, 1999). In many cases, people who have psychiatric diagnoses are being made scapegoats for society's violence when, in fact, these persons are more likely to be victims of crime or suicide. In actuality, persons with mental illnesses account for a very small percentage of the violence in American society. In a 1998 study, Monahan found that the prevalence of violence among people who have been discharged from a hospital and who do not have symptoms of substance abuse is about the same as the prevalence of violence among other people living in their communities who do not have symptoms of substance abuse (Monahan, 1998). In fact, the study concluded

that only 3 percent of violence in American society comes from persons with mental illnesses.

The public's perception that persons with mental illness are violent is exacerbated by the increasing number of persons with mental illness who are involved with the criminal justice system. In addition, some advocates believe that the association of violence with mental illness is being actively promoted publicly, playing off people's fears for public protection in order to increase resources and funding for the mental health system.

**5.38. Recommendation:** The Legislature and the DMH should implement a campaign to help educate the public about the misperception of the relationship between violence and mental illness.

### **Social Support Network**

A program description from the Long Beach Village Integrated Services Agency, entitled "The Village Concept," observes that the needs of persons with mental illness for social support are no different from those of most people. After the basic needs of food, shelter, and clothing are met, the need for friendship and social interaction becomes apparent. When sufficient opportunity is provided to meet these needs, the individual has a sense of being embedded in a larger community. The individual develops a sense of dignity, self-worth, and belonging by having a definite role to play and a place in which to be and to grow.

Socializing and recreation teaches people social skills, provides them with leisure-time activities, and offers them involvement in community activities. Holshuh (1992) makes the following observation about how mental illness interferes with these natural processes:

For persons with severe and persistent mental illnesses, onset of mental illness, acute episodes of symptoms, hospitalizations, and ongoing impairments have interfered with social development—forming relationships, making friends, getting married, getting and giving emotional support, and relating as adults with their families, employers, and landlords. In addition, these clients are a vulnerable group in need of but often lacking social support systems (Holshuh, 1992).

### **Spirituality**

**Problem:** Clinicians need to increase their understanding of the importance of spirituality to a client's recovery.

Spirituality is an important part of the human experience. Every culture contains within it approaches to spirituality and its expression in the life of the members within. Spirituality is defined variously by different cultures. Primarily, spirituality deals with a person's orientation to transcendence and connection to a higher sense of being and meaning in life. At times clients may have distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of other spiritual values that may not necessarily be related to an organized church or religious institution.

Many traditions present ways for individuals to access their spirituality and address some of these issues. Mental health providers should maintain respect for their clients' beliefs. Clinicians should obtain information on the religious or ideological orientation and beliefs of their clients so that they may consider the client's beliefs in the course of treatment. If an unexpected conflict arises in relation to such beliefs, it should be handled with a concern for the client's vulnerability to the attitudes of the clinician. Empathy for the client's sensibilities and particular beliefs is essential. Clinicians should maintain an open mind and attitude about spirituality in order to provide an opportunity for clients to bring their concerns into the treatment process.

**5.39. Recommendation:** Clinicians should become familiar with the Diagnostic and Statistical Manual IV section on religious or spiritual problems. Clinicians should not impose their own religious, anti-religious, or ideological systems of beliefs on their clients, nor should they substitute such beliefs or ritual for accepted diagnostic concepts.

### **Consumer-Operated Service Programs**

**Problem:** Consumer-operated services should receive more support in local mental health programs.

The self-help movement grew out of the idea that individuals who have experienced similar problems, life situations, or crises can effectively provide support to one another. Consumer-operated service programs offer

support based on first-hand experiences with various issues, such as medication, social security and other income supports, housing, employment, human service agencies, families, and friends. These groups are formed by peers. They offer emotional support, friendship, individual advocacy, information about mental health issues, and a way to improve the mental health system. Long (1988) describes the range of programs that are consumer-run and their benefits:

Consumer-operated programs include drop-in centers, case management programs, outreach programs, businesses, employment and housing programs, and crisis services, among others. Consumer staff are thought to gain meaningful work, to serve as role models for clients, and to enhance the sensitivity of the service system to the needs of people with mental disorders (Long, 1988).

A peer-run drop-in center provides an open, comfortable setting and often serves as the nucleus for a wide variety of support, service, and socialization activities. Services include self-help groups, training in independent living skills, advocacy and assistance in locating needed community resources and services, such as housing and financial aid, education about patients' rights, psychiatric drugs, and other topics of interest, social and recreational activities, and community or public education on mental illness.

**5.40. Recommendation:** The Governor and the Legislature should provide funding to ensure that consumer-run programs and peer supports are included as components in all local mental health services.

**5.41. Recommendation:** The State should provide training and technical assistance to local mental health programs to teach clients leadership, advocacy, and how to start and operate a peer support program.

**5.42. Recommendation:** The CMHPC should study the extent to which local mental health systems support opportunities for consumers to develop consumer-run services.

### **Families**

**Problem:** Families of persons with mental illness need education and support.

The Adult System of Care must recognize the importance of families in the treatment and recovery of their adult family members with mental illnesses. Many persons with mental disabilities live with or in life-long contact with their families. Many look to their families for moral support as well as for specific help in their individual recovery. Families can make significant contributions in assisting clients in treatment planning, health and dental care, consumer rights and advocacy, crisis response, and housing. Many times, families act as unofficial "case managers."

The family's culture, which may include immediate family, extended family, and ethnic communities, should be recognized as part of the client's support system. Many multicultural clients live with their families and receive their support and strength through their families. Many of these families are non-English speaking and may need access to interpreters. These families need education on mental illness so they can provide their ill family member support and help in their treatment decisions and recovery. These families also need an orientation to the mental health system and how to access services.

Many county mental health departments have hired a "Family Advocate" to act as a coordinator and resource person for families. This action has helped to ensure that families are involved in all stages of service delivery when desired by the client.

**5.43. Recommendation:** Family Advocates should be employed by both county-operated mental health programs and community mental health agencies.

**5.44. Recommendation:** Local mental health programs should provide families education and support to help them understand their family member's illness and how best to provide support to that family member.

**5.45. Recommendation:** Local mental health programs should develop family education programs targeted to the needs of racial, cultural, and ethnic families.

**Problem:** Family members of persons with mental disabilities lack respite services.

Family members of persons with mental disabilities also need support and respite services. They are under a great deal of stress caring for and obtaining resources for their

family members who are mentally ill. Family members also feel stigmatized by society's attitude toward their family member's illness. Support organizations, such as NAMI California, help family members cope with the added stress and find available resources. In addition, family self-help groups result in better communication and interaction among family members.

In 2000 the Joint Committee on Mental Health Reform (JCMHR) held a series of public hearings throughout the State to gather information and make recommendations about the mental health system. These hearings revealed that respite care is one of the greatest unmet needs of family members who care for children and adults with serious mental illness. Lack of respite services results in caregiver "burnout."

**5.46. Recommendation:** The mental health system should provide respite services to family members of persons with mental disabilities.

#### ***Community Involvement***

**Problem:** Clients and family members perceive a lack of involvement and partnership in the mental health system.

During the JCMHR hearings conducted in the spring of 2000, a recurrent theme kept surfacing that clients and family members felt a lack of respect and partnership in the mental health system as well as a lack of access and a meaningful role in system design and implementation. The JCMHR also heard repeatedly from clients and families who had benefited from peer support activities, including self-help programs and family support programs. Through the support of family and peers, clients begin to become more involved in their community. Many clients have become community activists, helping other clients to navigate the human services system in their community.

Clients are also becoming a political force. Campaigns to register to vote are underway as well as voter education to enable clients to vote for the candidates and measures that will benefit their lives the most. Clients are also volunteering in their communities for a variety of service-oriented tasks. Becoming involved in the community makes recovery a tangible goal.

**5.47. Recommendation:** The DMH and local mental health programs should provide training and resources to help clients and their families

have meaningful involvement in the design and implementation of mental health programs.

**5.48. Recommendation:** The mental health system should develop specific ways to integrate persons with mental disabilities into the community, including joint projects with civic groups; education of the community by family, client, and professional organizations; and media coverage and presentations to legislators, civic and business organizations, community agencies, and schools concerning mental health issues.

**Problem:** The mental health system lacks community resources to support outreach and education to clients, families, and communities.

Community involvement and community-based supports are extremely important, especially for clients from multicultural communities. Each region in California has a different need for community support based on the demographics of that area. More coordination is needed between various community organizations and agencies so that prevention services can be offered rather than providing costly inpatient services. In order to accomplish this goal, more bilingual, bicultural, and ethnically diverse clinicians are needed. In the meantime, the existing mental health work force should be educated to be more sensitive to ethnic and cultural differences and to recognize strengths within each cultural and ethnic community.

**5.49. Recommendation:** The DMH should assess the needs of each region in California and provide more resources to local communities to provide appropriate services, especially prevention and intervention.

**5.50. Recommendation:** The DMH and local mental health programs should provide special focus to ethnic communities to educate them how to support clients with mental illnesses and to assist mental health organizations to provide support to multicultural clients.

#### **Social and Cultural Stressors**

**Problem:** Social and cultural stressors of racism and discrimination contribute to the poor levels of clients' mental health.

Article 1 of the United Nations Declaration on the Elimination of All Forms of Racial Discrimination indicts racism, stating that

discrimination on the grounds of race, color, or ethnic origin is an offense to human dignity and shall be condemned as a violation of human rights and fundamental freedoms (General Assembly, 1963).

In addition to having a pernicious affect on the societal level, racism affects the health and mental health of racial and ethnic minorities:

Racism and discrimination are stressful events that adversely affect health and mental health. They place minorities at risk for mental disorders such as depression and anxiety. Whether racism and discrimination can by themselves cause these disorders is less clear, yet deserves research attention (U.S. Department of Health and Human Services, 2001, p. 42).

Research has shown the existence of striking disparities in access to mental health services

among ethnic groups (U.S. Department of Health and Human Services, 2001). According to the Surgeon General's Supplement on Mental Health, Race, Culture, and Ethnicity (2001), "Most minority groups are less likely than whites to use services, despite having similar community rates of mental disorders" (p. 3). Moreover, when minority populations receive mental health services, these are poor in quality (U.S. Department of Health and Human Services, 2001). "Lower utilization and poorer quality of care, means that minority communities have a higher proportion of individuals with unmet mental health needs" (p. 3).

Table 1 illustrates a disparity between whites and minority groups in utilization of mental health services. In contrast, the non-white group, who are 40 percent of the clients, received only 34 percent of the services.

**Table 1:** Number of Outpatient Medi-Cal Clients and Outpatient Units of Services for Fiscal Year 1999-2000 for Whites and Non-Whites

<b>Ethnicity</b>	<b>Clients Statewide</b>	<b>Percent</b>	<b>Outpatient Units</b>	<b>Percent</b>
<b>White</b>	155,712	60.49	4,050,794	65.91
<b>Non-White</b>	101,685	39.50	2,094,644	34.08
<b>Total</b>	257,397	100.00	6,145,438	100.00

Controversy exists over the causes of these disparities in utilization between whites and minority groups. The Surgeon General's report examines one potential cause: the issue of clinician bias and stereotyping. It indicates that clinicians often reflect the attitudes and discriminatory practices of their society, also known as institutional racism (Whaley, 1998). While racism and discrimination have diminished over time, traces remain, which appear as less overt medical practices concerning diagnosis, treatment, prescribing medications, and referrals (Giles, Anda, Casper, Escobedo, & Taylor, 1995). For example, African American patients are subject to overdiagnosis of schizophrenia and are underdiagnosed for bipolar disorder (Bell & Mehta, 1980), (Bell & Mehta, 1981), (Mukherjee, Shukla, Woodle, Rosen, & Olarte, 1983). In another example, widely held stereotypes of Asian Americans as "problem

free" may prompt clinicians to overlook their mental health problems (Takeuchi & Uehara, 1996).

The Surgeon General's report cautions that, although some of the racial and ethnic disparities it describes are likely the result of racism and discrimination by white clinicians, the limited research on this topic suggests that the issue is more complex. Mistrust of mental health services is also an important reason minorities do not seek treatment. Further study is needed on how to address issues of clinician bias and diagnostic accuracy (U.S. Department of Health and Human Services, 2001).

The Adult System of Care Framework developed by the California Mental Health Directors Association (CMHDA) articulates a vision of an ideal, fully funded, and culturally and linguistically competent, age appropriate, and

gender sensitive Adult System of Care.<sup>1</sup> Social and cultural stressors, including discrimination in employment, education and housing are identified. The framework provides numerous strategies that should be implemented to address these stressors directly. Implementation of the Adult System of Care Framework and training programs in the mental health system on the effects of racism will reduce and eventually eradicate the cases of racism and discrimination in the mental health system.

**5.51. Recommendation:** Local mental health programs should provide ongoing training to staff utilizing educational approaches on the effects and practices of racism. This training will increase awareness and cultural sensitivity of providers.

**5.52. Recommendation:** The DMH should ensure that training to combat racism is offered by local mental health programs in a timely fashion and meets acceptable standards relevant to cultural and ethnic issues.

**5.53. Recommendation:** The State Quality Improvement Council should monitor trends in the utilization of modes of services by ethnicity and develop recommendations to eliminate racial and ethnic disparities should they persist over time.

**Problem:** Mental health providers do not address the level of acculturation and the racial, cultural, and ethnic identity of ethnically diverse clients.

Acculturation refers to the process that leads to changes in a person's values, attitudes, and behaviors as a result of interaction with a second culture (Aponte & Johnson, 2000). Moving to a new culture may require adjustments in some or all of the aspects of daily living, including language, work, shopping, housing, children's schooling, health care, recreation, and social life. Acculturation is often considered to have an impact on the mental health of the individual who is experiencing the process of acculturation (Kvernmo, 1998). Some persons choose to acculturate by immigrating to a new country; others have been forced to take part in it, e.g., indigenous people and refugees. When

individuals experience acculturation and the process is too overwhelming, creating problems that they cannot resolve, acculturation will result in stress and psychopathology (Kvernmo, 1998).

Another important concept in identifying the psychological needs of ethnically diverse clients is ethnic or racial identity. Ethnic or racial identity relates to the process and outcome of integrating ethnic and racial aspects into a person's overall self-concept and identity (Helms, 1990). Identity development is a psychological process in which individuals become aware of or ascribe meaning to racial or cultural material and integrate this information into their overall self-concept (Aponte & Johnson, 2000). Ethnic identity describes an individual's awareness and sense of self as a racial, ethnic, or cultural being.

To serve ethnically diverse clients, mental health practitioners must be culturally aware enough to respond effectively to those that they hope to serve. Clinicians need to be aware of the client's acculturation process and incorporate it into services provided to the client. Numerous tools to assess an individual's level of acculturation are available, some of which are specific to particular ethnic groups and many of which have been translated into the major languages of California's diverse populations. The Acculturation Rating Scale for Mexican Americans developed by I. Cuellar is one of the most widely used instruments.

**5.54. Recommendation:** Local mental health programs should evaluate the awareness, sensitivity, and respect for the acculturation process of mental health providers and support staff in order to guarantee appropriate engagement with racially, culturally, and ethnically diverse mental health clients.

**5.55. Recommendation:** Local mental health programs should evaluate clinicians' therapeutic skills and cultural knowledge to ensure that it is compatible with the needs of ethnically diverse clients that the clinician serves.

**5.56. Recommendation:** Local mental health programs should increase training for clinicians to address the dynamics of the acculturation process and its relationship to diverse communities and their mental health treatment needs.

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<sup>1</sup> The Adult System of Care Framework can be accessed online at [www.cmhda.org/documents.html#assoc](http://www.cmhda.org/documents.html#assoc).

## REFERENCES

- Allness, D., & Knoedler, W. (1998). *The PACT model of community-based treatment for persons with severe and persistent mental illnesses: A manual for PACT start-up*.
- Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*.
- Aponte, J. F., & Johnson, L. R. (2000). The impact of culture on the intervention and treatment of ethnic populations. In J. F. Aponte & J. Wohl (Eds.), *Psychological intervention and cultural diversity*. Boston: Allyn and Bacon.
- Bell, C. C., & Mehta, H. (1980). The misdiagnosis of black patients with manic depressive illness. *Journal of the National Medical Association*, 72, 141-145.
- Bell, C. C., & Mehta, H. (1981). The misdiagnosis of black patients with manic depressive illness: Second in a series. *Journal of the National Medical Association*, 73, 101-107.
- Brown, E. R., Ojeda, V. D., Wyn, R., & Levan, R. (2000). *Racial and ethnic disparities in access to health insurance and health care*. Los Angeles, CA: UCLA Center for Health Policy and Research, The Henry J. Kaiser Family Foundation.
- Brown, E. R., Wyn, R., Hongjian, W., Valenzuela, A., & Dong, L. (1999). Access to health insurance and health care for children in immigrant families. In D. J. Hernandez (Ed.), *Children of immigrants*. Washington, DC: National Academy of Sciences.
- California Department of Mental Health. (1997a). *The California State Department of Mental Health*. Sacramento.
- California Department of Mental Health. (1997b). *Dual diagnosis program*. Retrieved, from the World Wide Web: <http://www.dmh.cahwnet.gov/PGRE/dualdiag.htm>
- California Department of Mental Health. (1998). DMH information notice no.: 98-20. Sacramento, CA.
- California Institute for Mental Health. (1999). *Gender matters: Building a system of services and treatment for women in California*. Sacramento, CA.
- California Medical Association. (1998). Resolution 710-98: Primary care physicians and mental illness screening.
- California Mental Health Directors Association. (2000). *Adult system of care framework*. Retrieved, from the World Wide Web: [www.cmhda.org/documents.html#asoc](http://www.cmhda.org/documents.html#asoc).
- Craig, D. J. (2001, March 21). New BU institute to study schizophrenia rehabilitation and recovery. *B.U. Bridge*.
- Egnew, R., & Geary, C. (1996). Coordinating physical and behavioral healthcare services for Medicaid populations: Issues and implications in integrated and carve-out systems. *Behavioral Healthcare Tomorrow*, 67-71.
- Escobar, J. I., Burnam, M. A., Karno, M., Forsythe, A., & Golding, J. M. (1987). Somatization in the community: Relationship to disability and the use of services. *General Psychiatry*, 44, 713-718.
- General Assembly. (1963). United Nations declaration on the elimination of all forms of racial discrimination. New York, NY: Secretariat Centre for Human Rights, United Nations.
- Giles, W. H., Anda, R. F., Casper, M. L., Escobedo, L. G., & Taylor, H. A. (1995). Race and sex differences in rates of invasive cardiac procedures in U.S. hospitals. Data from the National Hospital Discharge Survey. *Archives of Internal Medicine*, 155, 318-324.
- Groshart, J. (1997). *Providing services to students with psychological disabilities*. Sacramento: California Association of Public Education Directors.
- Helms, J. E. (Ed.). (1990). *Black and white racial identity: Theory, research, and practice*. New York: Greenwood Press.



- Holshuh, J. (1992). *Social functioning and social networks among the chronic mentally ill*. University of California, Berkeley.
- Hsu, L. K., & Folstein, M. F. (1997). Somatoform disorders in Caucasian and Chinese Americans. *Journal of Nervous and Mental Disease*, 185, 382-387.
- Izumi, L., Schiller, M., & Hayward, S. (1996). *Corrections, criminal justice, and the mentally ill: Some observations about costs in California*.
- Kaplan, A., Sadock, B., & Grebb, J. (1998). *Synopsis of psychiatry* (7th ed.): Lippincot, Williams & Wilkins.
- Koran, L. (1985). *Physical illness in a sampling of California psychiatric patients*. Paper presented at the Academy of Psychosomatic Medicine 32nd Annual Meeting.
- Kvernmo, S. (1998). Language and ethnic identity in indigenous adolescents. In E. E. A. Skoe & A. L. Von Der Lippe (Eds.), *Personality development in adolescence: A cross national and life span perspective* (pp. 123-140). Florence: KY: Taylor & Francis/Routledge.
- Long, V. T. (1988). National Resource Center on Homelessness and Mental Illness.
- Los Angeles County Task Force on the Incarcerated Mentally Ill. (1993). *Final report to the Los Angeles County Board of Supervisors*.
- Mahler, J., Tavano, S., Gerard, C., & Baber, P. (2001). *The recovery model: A conceptual framework and implementation plan*. Concord, CA: The Contra Costa County Mental Health Recovery Task Force.
- Manisses Communications Group, I. (2002). SAMHSA releases preliminary draft of co-occurring report. *Alcoholism & Drug Abuse Weekly*, 14, 2-3.
- Mead, S. M., & Copeland, M. E. (2000). What recovery means to us: Consumers' perspectives. *Community Mental Health Journal*, 36(3), 315-328.
- Monahan, J. (1998). *The MacArthur violence risk assessment study*.
- Monahan, J., Link, B., Stueve, A., & Kikuzawa, S. (1999). The public's view of the competence, dangerousness, and need for legal coercion of persons with mental health problems. *American Journal of Public Health*, 89(9), 1339-1345.
- Mukherjee, S., Shukla, S., Woodle, J., Rosen, A. M., & Olarte, S. (1983). Misdiagnosis of schizophrenia in bipolar patients: A multiethnic comparison. *American Journal of Psychiatry*, 140, 1571-1574.
- National Alliance for the Mentally Ill. (2000). *Employment, work, and income supports for people with brain disorders*. Retrieved 2/9, 2000, from the World Wide Web:
- National Association of State Mental Health Program Directors. (2000). NASMHPD position statement on employment and rehabilitation.
- National Council on Disability. (1997). *Removing barriers to work: Action proposals for the 105th congress and beyond*.
- National Institute of Mental Health. (1987). *Toward a model plan for a comprehensive community-based mental health system*.
- Parten, D., & Tracy, G. (in press). California community colleges experiences: Evaluation of the community college system and exemplary programs for students with psychological disabilities. In International Association of Psychosocial Rehabilitation Agencies & B. University (Eds.), *Supported education and psychiatric rehabilitation*.
- Ralph, R. O. (2000). *A synthesis of a sample of recovery literature 2000*. Portland: University of Southern Maine.
- Snowden, L. R., & Thomas, K. (2000). Medicaid and African American outpatient treatment. *Mental Health Services Research*, 2, 115-120.

- Takeuchi, D. T., & Uehara, E. S. (1996). Ethnic minority mental health services: Current research and future conceptual directions. In B. L. Levin & J. Petrila (Eds.), *Mental health services: A public health perspective* (pp. 63-80). New York: Oxford University Press.
- Tootelian, D. H., & Gaedeke, R. M. (1999). *The impact of housing availability, accessibility, and affordability on people with disabilities*. Sacramento: State Independent Living Council.
- Turner, J. E., & Shifren, I. (1979). Community support systems: How comprehensive? *New Directions for Mental Health Services*, 2, 1-23.
- U.S. Department of Health and Human Services. (1999). *Mental health: A report of the surgeon general*. Rockville, MD: Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
- U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity -- A supplement to mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- Whaley, A. L. (1998). Issues of validity in empirical tests of stereotype threat theory. *American Psychologist*, 5, 679-680.